Interim Home Medical Equipment

512-686-2505 p

512-727-8766 f

Please do not only fax to order, always call to confirm the order was received and the delivery address is in our service area

We are a PRIVATE PAY provider so we will not bill any insurance or medicare

Date____/_____/_____ **DME Order Form**

Patient Name_____ **D.O.B**____/____/____

Patient Phone(_____) _____-_____ **Height**_____ft_____in **Weight**_____LBS

Home Address_____

Deliver To_____**RM**_____

Patient's Contact_____ **Phone**(_____) _____-_____

Equipment

Hospital Bed □ | half rails □ | full rails □ | no rails □
Lift Chair □
Low Air Loss Mattress □
Wheelchair 16" □ 18" □ 20" □ | Elevating Leg Rests □
Reclining Wheelchair 16" □ 18" □ 20" □
Transport Chair □
Knee Scooter □
Trapeze Bar □
APP □
Over Bed Table □
Walker □
Bedside Commode □
Rolling Shower Chair □
Shower Chair W/ BackRest □
Shower Chair W/ Back & Arm Rests □
Transfer Bench □
Other □ : _____

Ordered by:_____Length of Need:_____(99/Lifetime)

Direct Phone:(_____) _____-_____ Fax Line:(_____) _____-_____

Dr. Office or Facility:_____

Physician/ Practitioner Name:_____

Physician/ Practitioner Signature:_____

NPI:_____ Date:____/____/_____ Time:___:_____ _____